METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care

The following is a description of the policy and methods used in establishing payment rates for each type of care and services included in the State plan.

Medical Assistance payment for Medicare crossover claims is equal to the Medicare co-insurance and deductible.

Services provided by facilities of the Indian Health Service (which include, ~~effective July 11, 1996,~~ at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, operating as 638 facilities) are paid at the rates negotiated between the Indian Health Service and the Health Care Financing Administration and published by the Indian Health Service in the Federal Register.

Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Health Care Financing Administration) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.

Except in the case of critical access hospitals, for obstetric care the base rate is adjusted as follows:

- outpatient hospital obstetric care (as defined by the Department)technical component (provided by outpatient hospital facilities) receives a 10% increase over the base rate.

- all other obstetric care (as defined by the Department) receives a 26.5% increase over the base rate.

Pediatric care (as defined by the Department), except for the technical component provided by an outpatient hospital facility, receives a 15% increase over the base rate.

Legislation governing maximum payment rates sets the calendar year at 1989, except that the calendar year for item 7, home health services, is set at 1982. Rates for services provided by community and public health clinics are increased by 20%, except for laboratory services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

Exceptions to the 50th percentile of the submitted charges occur in the following situations:

(1) There were less than 5 billings in the calendar year specified in legislation governing maximum payment rates;
(2) The service was not available in the calendar year specified in legislation governing maximum payment rates;
(3) The payment amount is the result of a provider appeal;
(4) The procedure code description has changed since the calendar year specified in the legislation governing maximum payment rates, therefore, the prevailing charge information reflects the same code but a different procedure description;
(5) The 50th percentile reflects a payment which is inequitable when compared with payment rates for procedures or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category; or
(6) The procedure code is for an unlisted service.

In these instances, the following methodology is used to reconstruct a rate comparable to the 50th percentile of charges submitted in the calendar year specified in legislation governing maximum payment rates:

(1) Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; and/or
(2) Refer to surrounding and/or comparable procedure codes; and/or
(3) Refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates; and "backdown" the amount by applying an appropriate CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI; and/or
(4) Refer to relative value indexes; and/or
(5) Refer to payment information from other third parties, such as Medicare; and/or
(6) Refer to a previous rate and add the aggregate increase to the previous rate; and/or
(7) Refer to the submitted charge and "backdown" the charge by the CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI.

If a procedure was authorized and approved prior to a reference file rate change, the approved authorized payment rate may be paid rather than the new reference file allowable.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

HCPCS MODIFIERS

Medical Assistance pays more than the reference file allowable in the following areas:

20 microsurgery = 35% additional reimbursement.

22 unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered.

99 multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99.

In accordance with Minnesota Statutes, §256B.37, subdivision 5a:

No Medical Assistance payment will be made when either covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.

Payment for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:

(1) the patient liability according to the provider/third party payer (insurer) agreement;

(2) covered charges minus the third party payment amount; or

(3) the Medical Assistance rate minus the third party payment amount.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

IHS/638 FACILITIES:

An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.

Services included in the outpatient rate include:

- outpatient hospital ambulatory surgical services
- outpatient physician services
- outpatient dental services
- pharmacy services
- home health agency/visiting nurse services
- outpatient chemical dependency services
- transportation services if the recipient is not admitted to an inpatient hospital within 24 hours of the ambulance trip

Services included in the inpatient rate include:

- inpatient hospital services
- transportation services if the recipient is admitted to an inpatient hospital within 24 hours of the ambulance trip

Inpatient physician services are paid in accordance with the methodology described in ~~Attachment 4.19-B,~~ item 6.d.C., Ambulatory surgical centers.

The ambulatory surgical center facility fee is paid in accordance with the methodology for the technical component of the surgical procedure described in ~~Attachment 4.19-B,~~ item 5.a., Physicians' services.

1. Inpatient hospital services other than those provided in an institution for mental diseases.

See Attachment 4.19-A.

2.a. Outpatient hospital services.

Payments for outpatient hospital services may not exceed in aggregate the total payments that would have been paid under Medicare.

Outpatient hospital services are paid as follows:

Emergency room operating charges are paid the lower of:

(1) submitted charge; or

(2) ~~105.6%~~ 114.04% of the 1990 average submitted charge:

a) Anesthesia supplies and materials are paid at ~~$189.44~~ $204.59.

b) Oxygen supplies are paid at ~~$37.11~~ $40.07.

c) Post-anesthesia observation is paid at ~~$67.98~~ $73.41 per 15 minute unit of service up to four hours.

d) Post-emergency care bed is paid at ~~$26.42~~ $28.51 per 15 minute unit of service up to four hours.

Miscellaneous outpatient hospital facility component charges are paid the lower of:

(1) submitted charge; or

(2)
- prolonged outpatient IV therapy = ~~$33.92~~ $36.63
- mental health observation bed = ~~$26.47~~ $28.58
- ~~unlisted outpatient facility fee = $26.47~~
- external fetal monitoring, four hours or less = ~~$52.11~~ $56.27
- external fetal monitoring, more than four hours = ~~$108.57~~ $117.25
- hemodialysis for outpatient, per treatment = submitted charge (through May 31, 1994)
- hemodialysis for outpatient, per treatment = in accordance with methodology for the Medicare program, regardless of service date (as of June 1, 1994)

Ambulatory surgical center facility services or facility components are paid in accordance with the methodology in item 6.d.C., Ambulatory surgical centers.

2.a. Outpatient hospital services. (continued)

The **emergency room facility charge** is paid the lower of:

(1) submitted charge; or
(2) (a) provider's cost for a 15 minute unit of services based on a 1983 cost report plus ~~32%~~ 42.56%; or
(b) if the provider did not submit a cost report, ~~$33.00~~ $35.64 for each 15 minute unit of service.

The **clinic facility charge** is paid the lower of:

(1) submitted charge; or
(2) (a) ~~$33.00~~ $35.64 for urgent care facility fee; or
(b) ~~$23.55~~ $25.43 for all other clinic facility fees.

Other outpatient hospital services as paid using the same methodology in item 5.a., Physicians' services.

Laboratory services are paid using the same methodology in item 3, Other laboratory and x-ray services.

Vaccines are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price plus $1.50 for administration.

Vaccines available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid the lower of:

(1) submitted charge; or
(2) the $8.50 administration fee.

All other injectables are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price.

2.a. Outpatient hospital services. (continued)

(2) the average wholesale price plus $8.50 for administration; or
(3) the $8.50 administration fee only if the provider receives free vaccine through the Minnesota Vaccines for Children Program.

All other injectables are paid the lower of:

(1) submitted charge; or
(2) the average wholesale price.

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2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

A. Provider Clinics

~~Payment~~ For clinics of rural hospitals with fewer than 50 beds, payment shall be ~~according~~ pursuant to 42 CFR §447.371(a) using the methodology ~~contained~~ established for independent clinics in 42 CFR §447.371(b) or (c)(1) and (3), at the percentages specified in §1902(a)(13)(C)(i) of the Social Security Act.

For ~~provider~~ clinics ~~when the hospital has~~ of urban hospitals, or clinics of rural hospitals with 50 or more beds, payment shall be pursuant to ~~§1833(f) of~~ 42 CFR §447.371(a) using the ~~Social Security Act~~ methodology established for independent clinics in 42 CFR §447.371(b)or (c)(1) and (3), at the percentages specified in §1902(a)(13)(C)(i) of the Act, applying the limit of §1833(f) of the Act to Medicare service costs.

B. Independent Clinics

For clinics that do not offer ambulatory services other than rural health clinic services, payment shall be pursuant to the methodology in 42 CFR §447.371(b), at the percentages specified in §1902(a)(13)(C)(i) of the Social Security Act, applying the limit of §1833(f) of the Act to Medicare service costs.

~~If a rural health clinic other than a provider clinic offers~~ For clinics that offer ambulatory services other than rural health clinic services, ~~maximum~~ payment ~~for these ambulatory services~~ shall be ~~at~~ pursuant to the ~~levels specified~~ methodology in ~~this part for similar services~~ 42 CFR §447.371(c)(1) and (3), at the percentages specified in §1902(a)(13)(C)(i) of the Act, applying the limit of §1833(f) of the Act to Medicare services costs.

For purposes of this item, "provider clinic" means a clinic as defined in 42 CFR §447.371(a); "rural health clinic services" means those services listed in 42 CFR §440.20(b); "ambulatory services ~~furnished by a rural health clinic~~" means those services listed in 42 CFR §440.20(c).

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC.

Payment shall be made in accordance with ~~§6303 of the *State Medicaid Manual*~~ §1902(a)(13)(C)(i) of the Social Security Act. An **interim** rate is established, subject to reconciliation at the end of the cost reporting period, using cost finding principles of 42 CFR §413.

The State uses the FQHC's audited Independent Rural Health Clinic/Freestanding Federally Qualified Health Center worksheet, Statistical Data, and Certification Statement to establish payment rates. The State makes adjustments for:

(1) Medicaid coverage of services ~~which~~ that differs from Medicare coverage;

(2) the applicable visits; and

(3) the establishment of a separate dental payment rate, if dental services are provided.

The State limits like services for Medicare and Medicaid to the respective Medicare limit for the year. Time periods that span more than one calendar year are limited to the respective Medicare limit for each time period.